

register, to which intensive care units in those cities have access. It is too early to judge the success of these schemes, but the hope is that they will eventually form a national network for those who are prepared to opt in. Many might think that a system of opting out—that is, placing your name on a register if you do *not* wish to be a donor—is simpler, but the implied pressure on people to put their name on a list has never gained favour in governments, who have remained wary of this type of legislation.

A method that both locates potential donors and shifts the responsibility of asking permission for organ donation from doctors has been introduced in the United States. Some 38 of the states have enacted laws that require hospitals to inquire routinely about potential organ donation (“routine inquiry”) or actually to request that an organ donation be approved by the next of kin (“required request”); last autumn legislation on required request became a federal law.⁵ Every primary care hospital must now develop a protocol to identify potential organ and tissue donors.⁶ Guidelines have been published for hospital administrators,⁷ and hospitals throughout the United States are now developing their own protocols. Will this scheme succeed any more than others in increasing organ donation? Any judgment is premature, but this legislation cannot be ignored: implementation of the protocol for required request is now a condition for federal reimbursement for health care.

The belief in the United States that legislation is needed to increase organ donation is in sharp contrast with the report of the British working party on supply of donor organs for transplantation released at the beginning of this year. The report makes recommendations to encourage better

knowledge of the needs for organ donation, to audit better those patients with brain stem death, and to encourage the public—mainly by extending the donor card system. Required request was considered but rejected.

We thus have a “more of the same” report in Britain and remarkable, positive, new legislation in the United States. My view is that the softly softly approach of the past 25 years was correct but is now not enough. The public are fully supportive of organ donation, and the results of heart, liver, and kidney transplantation no longer need to be justified. Kidney transplants have been shown repeatedly to be more cost effective than dialysis,⁸ yet the emphasis remains on increasing dialysis facilities. To make any real impact on the gap between demand and supply we need a new approach to organ donation.

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- 1 *United Kingdom Transplant Service Bulletin* 1988;No 51:2.
- 2 Jennett B, Hesse C. Brain death in Britain as reflected in renal donors. *Br Med J* 1981;283:359-62.
- 3 Overcast TD, Evans RW, Bowen LE, Hoe MM, Livak CL. Problems in the identification of potential organ donors. Misconceptions and fallacies associated with donor cards. *JAMA* 1984;251:1559-62.
- 4 Bay WH, Hebert LA. The living donor in kidney transplantation. *Ann of Intern Med* 1987;106:719-27.
- 5 US Public Law 99-509 Section 9318.
- 6 Organ donation and procurement: What responsibility does the hospital have? *Health Technology* 1987;1:182-90.
- 7 Warren J, Gill B. *Guidelines for hospital administration for implementing required request*. American Council on Transplantation, 1987.
- 8 Mancini PV. *The costs of treating end-stage renal failure*. London: Economic Advisers' Office, Department of Health and Social Security, 1984.
- 9 Wood IT, Mallick NP, Wing AJ. Prediction of resources needed to achieve the national target for treatment of renal failure. *Br Med J* 1987;294:1467-70.

Contact tracing for HIV infection

Contact tracing is vital in controlling sexually transmitted diseases. The aim is to break the chain of disease transmission by early identification and treatment of exposed people, thus reducing further spread and limiting the pool of asymptomatic but infectious individuals. A graphic illustration of a chain of heterosexual transmission of human immunodeficiency virus (HIV) was provided in a Swedish report (C Franzen *et al*, second international conference on AIDS, Paris 1986): four cases of heterosexually acquired infection (three in a woman and one in a man) and one of vertically acquired infection were traced back to an infected Swedish seaman. In another report 10 of 19 female contacts of an infected African engineer were infected (Clumeck N, *et al*, third international conference on AIDS, Washington 1987). When 90% of HIV infection is transmitted sexually why is contact tracing not used more widely? Should we encourage it?

The success of contact tracing in gonococcal, syphilitic, and chlamydial infections depends on characteristics shown by the diseases: there is a symptomatic phase of infection in many patients; the incubation period is short so that only recent contacts need to be traced; transmission between sexual partners occurs often; they can be effectively treated; and treatment confers a clear benefit. Few, if any, of these criteria hold true for infection with HIV. Early infection is often asymptomatic; the incubation period may last many years; the infectious period is uncertain; there is no effective treatment for asymptomatic disease; and diagnosis confers

few benefits and several disadvantages on the individual, while the benefits to society depend on the individual's subsequent sexual restraint.¹ These characteristics of HIV infection and the high prevalence in certain groups led to a prevention strategy that encouraged safe sex for all without necessarily identifying infected individuals. The arguments for contact tracing are stronger, however, in populations with a low prevalence of infection, where people may not perceive themselves to be at risk.

In the United States clear guidelines have emerged on contact tracing. The Centers for Disease Control has recommended contact tracing since 1985,² and in 1987 it said: “If [people infected with HIV] are unwilling to notify their partners . . . physicians or health department personnel should use confidential procedures to assure that the partners are notified.”³ This stance is supported by the US Surgeon General.⁴ The American Secretary of Education has gone further and suggested that positive test results should be reported to, among others, the sexual partners of those tested.⁵ Not surprisingly, contrary views exist, and Osborn has recently argued that tracing contacts has never worked well, depends on the cooperation of the index case, and may drive the disease underground.⁶

The logistics of contact tracing are daunting, given that one to one and a half million people are thought to be infected in the United States. This realisation has led to the suggestion that all those in high risk groups should come for testing

and that contact tracing should be reserved for those at lower risk, who may not come forward for testing.⁷ This detection of the asymptomatic and unaware carrier will reduce the transmission from them to their partners and unborn children.^{7,8}

An examination of why contact tracing has not developed in Britain inevitably starts to coalesce with the arguments about the benefits and disadvantages of screening. Should infected people be sought when there is no treatment and when a positive test result may lead to anxiety, stigmatisation, and discrimination? There is a tension between the interests of the individual and those of the public. Those who represent individuals mostly oppose contact tracing. Those who believe that the balance must be towards the public health and breaking the chain of transmission argue for it.⁹ They also suggest that tested individuals will benefit by learning how to adopt safe sex techniques and altering sexual behaviour¹⁰ as a result of their antibody status.

Two factors should sharpen our thinking: the law and therapeutic developments. What will the law say if a patient refuses to tell a contact or allow a health adviser to do so? Most genitourinary physicians would not inform a third party because it would breach confidentiality and drive the disease underground. The law, however, might take a different stance and support spouses or partners who brought a case against doctors, arguing that because they were not informed they became infected. Soon we may also need to consider the increasing complexity of prognostic markers and of treatment of the antibody positive patient to prevent progression of AIDS. This might make doctors think that it

would be unethical not to be able to offer such treatments to the unidentified partner.

We do not have the answers to the questions we have raised, but we think it better to start a discussion about contact tracing now rather than, as has happened all too often with AIDS, when there is a crisis. Then political expediency is given greater priority than humane and rational consideration.

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- 1 Miller D, Jeffries DJ, Green J, *et al.* HTLV III: Should testing ever be routine. *Br Med J* 1986;292:941-3.
- 2 Centers for Disease Control. Additional recommendations to reduce sexual and drug abuse related transmission of human T-lymphotropic virus type III/lymphadenopathy associated virus. *MMWR* 1986;35:152-5.
- 3 Centers for Disease Control. Public Health Service guidelines for counselling and antibody testing to prevent HIV infection and AIDS. *MMWR* 1987;36:509-15.
- 4 Koop CE. *Surgeon General's report on acquired immune deficiency syndrome*. Washington D.C: Public Health Service US Department of Health and Human Services, 1986.
- 5 Werner LM. Education Chief presses AIDS tests. *New York Times*, May 1 1987: A18.
- 6 Osborn JE. AIDS: politics and science. *N Engl J Med* 1988;318:444-7.
- 7 Francis DP, Chin J. The prevention of acquired immunodeficiency syndrome in the United States: an objective strategy for medicine, public health, business and the community. *JAMA* 1987;257:1357-66.
- 8 Rutherford GW, Oliva GE, Grossman M, *et al.* Guidelines for control of perinatally transmitted Human Immunodeficiency virus infection and care of infected mothers, infants and children. *West J Med* 1987;147:104-8.
- 9 Kinghorn G. HTLV III: Should testing ever be routine? *Br Med J* 1986;292:1202.
- 10 Fox R, Odaka NJ, Brookmeyer R, *et al.* Effect of HIV antibody disclosure on subsequent activity in homosexual men. *AIDS* 1987;1:241-6.

Disciplining doctors: the need for better methods

If serious disciplinary charges are made by National Health Service employers against doctors circular HM(61)112 contains a procedure that can be followed. Its use has become common practice over the past 27 years, and in 1987 community doctors were included along with hospital staff. It would now be difficult not to follow it. Nevertheless, there has been mounting criticism over its application, resulting in the current discussions between the Joint Consultants Committee and the Department of Health, and a proposal from the JCC to set up local professional review machinery (30 April, p 1273). A comprehensive guide on the many ways in which a doctor's performance can be challenged has also just been published.¹

Doctors accused of personal misconduct are no different from any other NHS employees, and most health authorities have their own procedures based on the General Whitley Council conditions of service. So the employer must decide whether or not the charges relate to personal conduct, professional conduct, or professional competence. The General Medical Council's pamphlet *Professional Conduct and Discipline: Fitness to Practise* provides guidance on defining professional misconduct.² If a doctor is charged with both personal and professional misconduct or incompetence then the more serious charges relating to professional performance will require the (61)112 procedure. There are, however, still many grey areas between personal and professional misconduct. A doctor's defence society or union representative will invariably argue that a charge arises as a result of pursuit

of his or her profession. Most commonly these confusions arise from breakdowns in personal relationships. There will always be difficulties of definition whatever the procedure.

The (61)112 inquiry costs an enormous amount of time and money and leads to trauma for the accused, witnesses, and their families. As the charge is serious it is usually necessary to suspend the doctor on full pay until investigations have shown that a case exists and until a response to the allegations has been received from the doctor. The suspension remains in force if an investigating panel, under a legally qualified chairman, is set up. If the employing authority in the end decides to dismiss the employee then an appeal can be made to the Secretary of State, and careful preparation is crucial for both the employer and the employee's adviser. The costs may thus run into hundreds of thousands of pounds. But why does it take a year or more for the Secretary of State to determine an appeal? Furthermore, after legal procedures have been followed so carefully during the investigation it seems extraordinary that the appeal is heard by a panel without a legally qualified chairman and composed mainly of professional members, even when the practitioner has been dismissed for professional misconduct.

An additional difficulty facing employers is that there is no established procedure for dealing with allegations of professional misconduct or incompetence that are not so serious as to lead to dismissal or a final warning. The regional medical officers of England shared their experiences a few years ago and identified a clear need for a simpler and quicker